REQUEST FOR SERVICES

ND DEPARTMENT OF HUMAN SERVICES
CHILDREN'S SPECIAL HEALTH SERVICES
SFN 1103 (Rev. 4-2005)

Clear Fields

Concerns regarding the application process or authorized services should be sent in writing to Children's Special Health Services, ND Department of Human Services, 600 E Boulevard Ave Dept 325, Bismarck, ND 58505-0269. Questions can be directed to CSHS at 1-800-755-2714.	**INSTRUCTIONS:** Complete Section I and II if applicant is requesting a diagnostic examination only. If applicant needs financial assistance to start treatment, complete Section I and III to apply for services. **Note Section IV is completed by the State Office.**

SECTION I. CLIENT INFORMATION

Name of Client:	Social Security Number:	Birthdate:

SECTION II. DIAGNOSTIC APPLICATION

1. Request Diagnostic Services by: (Specialist's Name)	Specialist's Address: (Clinic Name and City)		
2. Describe disability or medical problem:			
Signature of Applicant:	Date:	Relationship to Client:	County:
I understand that this is a request for diagnostic services only. If financial assistance is needed for treatment, Section III "Treatment Application" needs to be completed.	Signature of CSSB Representative:		Date:

SECTION III. TREATMENT APPLICATION

I am requesting assistance for the following medical condition(s):			
I understand that Children's Special Health Services (CSHS) does not cover sums for which there is any type of insurance coverage; or for which there is a recovery of money relative to the physical or medical condition for which application is made and that CSHS is to be reimbursed for any payment for which recovery of funds is secured. I agree that the payment of any sums by CSHS for services which are covered by insurance or may be recoverable because of the legal liability of a third party, will result in an automatic assignment to CSHS of any claim for such sums and I hereby agree to such an assignment. I have read this application or had it read to me, and certify that all statements herein are true to the best of my knowledge.			
Signature of Applicant:	Date:	Relationship to Client:	County:
Signature of CSSB Representative:	Date:	Treatment Application: (Based on financial eligibility) ☐ Recommend Approval ☐ Approval NOT Recommended	

SECTION IV. DISPOSITION (To Be Completed by State Office Only)

☐ 1. Diagnostic Application: ☐ Approved ☐ Not Approved Because:	Effective Date:
☐ 2. Treatment Application: ☐ Approved ☐ Not Approved Because:	Effective Date:
Signature of Medical Director/CSHS Designee:	Date:

No one shall be denied participation in or benefits of CSHS or be subject to discrimination on the basis of race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage or public assistance.

Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. It may also be used for the purposes of Medicaid reimbursement and reporting requirements of caseload numbers. Failure to disclose the social security number will not affect participation in this program.

DISTRIBUTION: Submit original to CSHS. Retain copy for CSSB file.